**Revocation of Authorization to Use and Disclose Protected Health Information (PHI)**

**County of Orange, California**

**Health Care Agency**

**INSTRUCTIONS**

**"Photocopy/Facsimile copy is as good as the original":** This statement is made to ensure that the patient/client knows that this request form may be photocopied and/or it may be sent via facsimile. The client/patient gives permission for the form to be sent by facsimile because accessibility of the information to recipients who are not the authorized users of the information may occur when the form is sent by facsimile.

**"Client/Patient Information"** to be completed by requestor.

**Name** Indicate the name of the client/patient whose records and/or information is being requested for disclosure

**AKA** Indicate any other name by which the client/patient is known.

**SSN** Indicate the Social Security Number of the client/patient.

**Date of Birth** Indicate the date of birth of the client/patient.

**"I, hereby REVOKE the authorization to use or disclose the named individual's Protected Health Information as described here."** The patient/client is stating that the authorization is being revoked, and is giving instructions regarding this revocation.

**Individual or organization originally authorized to use or disclose PHI:**

☐ **County of Orange, CA – Health Care Agency.** If the Authorization to Use or Disclose Protected Health Information (PHI) designated that the Health Care Agency is to use and disclose PHI, then check this box.

☐ **Other- Specify.** If another individual, organization or facility was designated to use and disclose PHI, then check this box. Please include the name and the complete address.

**Individual or organization originally authorized to receive the information:**

☐ **Other - Specify**. If another individual, organization or facility was designated to receive the PHI, check this box. Please include the name and complete address.

☐ **County of Orange, CA – Health Care Agency.** If the Health Care Agency was designated to receive the PHI, check this box.

**Information on the Authorization to Use and Disclose that is being revoked.** If certain parts of the Authorization is being revoked, indicate this in the specific section which describes the different types of information.

Sample:

**RECORDS/INFO TO BE DISCLOSED: (Initial For Each Type Of Record To Be Disclosed. Please check all that apply)**

| [11] MEDICAL TREATMENT RECORDS/INFORMATION (California Civil Code 56.10, Title 17, Health and Safety Code 120175) AND OTHER INFORMATION | | | |
|---|---|---|---|
| [11A] Initials | [11B] Treatment Date(s): | [11C] Facility Location(s) | [11D] Type of Record(s)/Information to be Disclosed |
| JD | | **Revoke Authorization** | ☒ Any and All<br>☐ Specific Record(s)/Info: (Please Indicate Below)<br>_____ |

**The types of PHI listed in the specific sections include the following. You can mark a certain section, or you can skip to the statement, "Limits of Revocation":**

**Medical Treatment Records/Information (California Civil Code 56.10, Title 17, Health and Safety Code 120175) and Other Information:**

**Psychiatric/Mental Health/Psychotherapy notes covered under California W&I Code 5328.**

**Alcohol/Substance Abuse records covered under Section 42, Part 2 Code of Federal Regulations.**

**HIV results/AIDS treatment records covered under Health and Safety Code 120980.**

**Limits of Revocation: I understand that this revocation will not apply to information that has already been released based on the authorization I signed on:** You can indicate the date you signed the authorization or you can provide a copy of the authorization that was previously signed and say, "See Attached."

The Custodian of Records staff may be able to provide a copy of this authorization form if available in our files. The Revocation form will not be applicable to information has already been disclosed pursuant to the Authorization to Use and Disclose Protected Health Information.

**Today's Date:** This **must** be completed in order for the Revocation to be valid. If no date is indicated, the revocation is not valid.

**Signature:** Requestor must sign the form to make Revocation legal.

**Note: The signature will be compared to the information in the medical record, or you may be asked to provide identification.**

**Printed Name:** Clearly print the name of person signing the revocation.

**Relationship:** Please mark the box to indicate the relationship of the person signing the form. If you are the patient, mark client (patient), if you are the parent of the patient mark parent, etc. If none of the provided boxes apply to you, please mark other and fill in your relationship to the patient. Note: Supplemental documents that prove your relationship to the client/patient must be provided.

**Complete Address:** Please fill in the complete address of the person who is signing the form.

**Telephone #:** Please fill in telephone number of the person who is signing the form.

**Please return the completed form for processing to the Custodian of Records office, 511 N. Sycamore, Santa Ana, Ca 92701. Phone (714) 834-3536; Fax (714) 835-9312.**

**Protected Health Information will no longer be used or disclosed pursuant to the authorization form as instructed by this Revocation form.**

**Distribution:** The bottom of the form indicates who will receive a copy of this request. The client/patient has a right to receive a copy of this form.

**If you have any questions, please call the Health Care Agency Custodian of Records Office at (714) 834-3536**